

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9316 CERTIFICATE OF DEATH

09308
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
Frederick <small>RURAL and give nearest town)</small>		MARYLAND Maryland <small>If outside corporate limits, write RURAL and give nearest town)</small>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Frederick	1 Day	600 Trail Avenue					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. DATE OF DEATH					
Frederick Memorial Hospital		Month	Day				
3. NAME OF DECEASED (Type or print)		First	Middle				
		WARD	AMERICUS ANGLEBERGER				
4. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>				
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>				
7. B. DATE OF BIRTH		8. AGE (In years lost birthday)					
		January 17, 1888	68 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY					
Cheif Clerk		Oil Company					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Maryland		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Milton H. Angleberger		Jeanette Stull					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.					
Yes		WWI					
17. INFORMANT		600 Trail Avenue, Mrs. Effie M. Angleberger, Frederick, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 4 hrs.							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease with hypertension 8 yrs.							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 9/4 , 1956, to 9/10 , 1956, that I last saw the deceased alive on 9/10 , 1956, and that death occurred at 6:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE Henry V Chase				East Church Street, Frederick, Md. 9/11/1956			
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 13 Sept 56		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth L. Heck		24b. REGISTRAR'S SIGNATURE	
				DATE 13 Sept 1956			

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF SERVICE

BUREAU V. S.

SEP 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

19309

9317

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 35 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 144 East South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARY		First MARY	Middle AGNES	Los BEACHT	4. DATE OF DEATH September 6, 1956	Month September	Day 6	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Nov 1891		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John M. O'Conner		14. MOTHER'S MAIDEN NAME Lillian R. Miller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ralph J. Beacht (Same as item #2)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Posterior Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Anterior-sclerotic lead disease (rupture of myocardial infarction)						INTERVAL BETWEEN ONSET AND DEATH 48 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 7 E. Church St., Frederick, Md.	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from Sept 4, 1956 , to Sept 6, 1956 , that I last saw the deceased alive on Sept 6, 1956 , and that death occurred at 5:32 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Robert S. Turner, Jr., M.D. DATE SIGNED 9/7/56								
ACTUAL SIGNATURE Robert S. Turner, Jr., M.D.								
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9 Sept 1956	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS		24a. REC'D BY REGISTRAR DATE Sept. 1956 Elizabeth G. Herb	24b. REGISTRAR'S SIGNATURE		

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69310

Item 18 Film G205 10-11-56 ams

9336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cedar Grove

c. LENGTH OF STAY IN 1b

4 mos.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Pennsylvania

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Loysville

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Sept.

28

1956

5. SEX

m

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 29 1895

9. AGE (In years
lost, birthday)

61

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mason Helper

10b. KIND OF BUSINESS OR INDUSTRY

7. Y. Central R.R.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Blue

14. MOTHER'S MAIDEN NAME

Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

Yes ✓ World War I

16. SOCIAL SECURITY NO.

109-14-0111 Mrs Florence Blue, Loysville, Pa.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
443 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Cerebral thrombosis 3 days
DUE TO (b)		Hypertensive CVD (Cardiovascular dis. 10 years)
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from _____	1956	to	1956	that I last saw the deceased alive on	21 Sept 1956	and that death occurred at	5 P.M.	from the causes and on the date stated above.
ACTUAL SIGNATURE	JAMES E. STONE, Jr.	M.D.	ADDRESS	Walpersville, Md.	DATE SIGNED	19 SEP 56		
PHYSICIAN'S NAME (Type)	JAMES E. STONE, Jr.		WALPERSVILLE, Md.					

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county)
Burial	Oct. 1, 1956	Chapel,	Mr. Libertoform
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
G.C. Barton, Walkersville, Md.		DATE 30 Oct 1956	D.H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

OCT 4 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9337

CERTIFICATE OF DEATH

09311

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Johnsville</u>		c. LENGTH OF STAY IN 1b <u>33 yrs</u>		c. CORPORATE TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Johnsville</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>IDA</u>		First <u>E</u>	Middle <u></u>	Last <u>Boone</u>	4. DATE OF DEATH <u>Sept. 28</u>	Month <u>Sept.</u>	Day <u>28</u>	Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u></u>	11. IF UNDER 24 HRS. Days <u></u>	12. IF UNDER 24 HRS. Hours <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Pittenger</u>		14. MOTHER'S MAIDEN NAME <u>Susan Fogle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Joseph A. Boone, Johnsville, Md</u>			
17. INFORMANT <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u></u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>		(b) <u></u>		(c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>Sept. 28 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Johnsville</u>		(County) <u>Baltimore</u>	(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Sept. 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 28</u> , 19 <u>56</u> , and that death occurred at <u>12 M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>J. H. Legg</u>		ADDRESS (Street, city or town, state) <u>Johnsville, Md.</u>							
PHYSICIAN'S NAME (Type) <u>J. H. Legg M.D.</u>		DATE SIGNED <u>9-29-56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Beaver Dam, old order</u>		22d. LOCATION (City, town, or county) <u>Johnsville</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Barton, Walkerville, Md.</u>		ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>Elizabeth G. Heis</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heis</u>			
VS A1S (4) ISM 9/55		DATE 3 Oct. 1956							

BUREAU V. S

OCT 4 1956

REGEV ELL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

119312

Reg. Dist. No.

131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Knoxville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Samuel W. Cockrell</i>		4. DATE OF DEATH <i>September 14 1956</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Dec. 9 1871</i>	9. AGE (In years last birthday) <i>84 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real estate and Insurance retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>George Cockrell, Knoxville, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO <i>491X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Brachial plexopathy</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>Sept. 15, 1956</i>
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-16-1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Wood</i>	22d. LOCATION (City, town, or county) (State) <i>Falls Church, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Lee Zeib</i>		ADDRESS <i>Brunswick, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>Sept. 18 1956</i>
			24b. REGISTRAR'S SIGNATURE <i>G. G. Zieba</i>

RECEIVED BY MAIL - MAIL ROOM - 1956 SEPTEMBER 18 - 1956

BUREAU V.

SEP 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9338

CERTIFICATE OF DEATH

09313

Reg. Dist. No.

139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph		First	Middle Albert	Last Coffman	4. DATE OF DEATH Month Sept	Day 24	Year 1956
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Age (In years from birthday) 84 yrs.	9. AGE (In years from birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Coffman		14. MOTHER'S MAIDEN NAME Margaret Willard					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. 218-24-1615		17. INFORMANT Howard A. Coffman		Address Blue Ridge Summit	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis Gr. IV (c) con. to failure.							
INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Sept 1956 , to 24 Sept 1956 , that I last saw the deceased alive on 23 Sept 1956 , and that death occurred at 12 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Blue Ridge Summit							
DATE SIGNED 24 Sept 1956							
ACTUAL SIGNATURE Harry H. Young Jr.							
PHYSICIAN'S NAME (Type) Harry H. Young Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-26-56		22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cemetery		22d. LOCATION (City, town, or county) Thurmont	
(State) Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Treacy							
ADDRESS Thurmont, Md.							
24a. REC'D BY REGISTRAR d. DATE 1956							
24b. REGISTRAR'S SIGNATURE Dad. B. Lyons							

LIBRARY K.S.

OCT 2 1956

LIBRARY K.S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9319

CERTIFICATE OF DEATH

Reg. Dist. No.

69314

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3		d. STREET ADDRESS Etzler Road, near Yellow Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DAVID	Middle VINCENT	Last CREBBS	4. DATE OF DEATH	Month September	Day 11	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 22 Jan 1876	9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY Building Painter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter D. Crebbs		14. MOTHER'S MAIDEN NAME Elizabeth Kaylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Res. no. or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Allen F. Harper, RD#3, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		DUE TO Sprained - pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aug 15, 1956, to Sept 11, 1956, that I last saw the deceased alive on Sept 10, 1956, and that death occurred at 9:45 P.M., from the causes and on the date stated above.					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.	(County) 7 N. Market St., Frederick, Md.
21. I certify that I attended the deceased from Aug 15, 1956, to Sept 11, 1956, that I last saw the deceased alive on Sept 10, 1956, and that death occurred at 9:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) H. F. Kline M.D. 7 N. Market St., Frederick, Md. 9/12/56 DATE SIGNED							
ACTUAL SIGNATURE H. F. Kline							
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 Sept 1956		22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Hill Cemetery		22d. LOCATION (City, town, or county) Frederick County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR Elisabeth G. Heek		24b. REGISTRAR'S SIGNATURE	
VS A15 (4) 15M 9/55				DATE 17 Sept 1956			

SEARCHED

SEP 4 1982

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1951

9320

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 708 N. Market Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crutchley Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARY	Middle BELLE	Last CRUTCHLEY	4. DATE OF DEATH	Month September	Day 12	Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH August 25, 1871	8. AGE (in years less birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Don't Know			14. MOTHER'S MAIDEN NAME Don't Know					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Mary E. Crutchley - 708 N. Market St.	Address Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis								INTERVAL BETWEEN ONSET AND DEATH
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____								
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Sept. 1, 1956 , to Sept. 12, 1956 , that I last saw the deceased alive on Sept. 11, 1956 , and that death occurred at 9:30 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>H. J. Slusher</i> ADDRESS (Street, city or town, state) Md. DATE SIGNED 9 East Church Street-Frederick 9/13/56								
PHYSICIAN'S NAME (Type) Dr. H. J. Slusher		9 East Church Street - Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/14/1956	22c. NAME OF CEMETERY OR CREMATORIUM Columbia Gardens	22d. LOCATION (City, town, or county) Arlington, (State) Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE <i>C E Cline & Son - Frederick - Md.</i>		ADDRESS WV.	24a. REC'D BY REGISTRAR Elizabetta G. Heek	DATE 14 Sept. 1956	24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1000

SEP 17 1962

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9339

CERTIFICATE OF DEATH

Reg. Dist. No.

49316

1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Braddock Heights

c. LENGTH OF STAY IN 1b
Monthsd. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Vindabona Convalescent Home

3. NAME OF
DECEASED
(Type or print)First
URSAMiddle
MILNERLast
DILLER4. DATE
OF
DEATHMonth
September
Day
16
Year
56

5. SEX

Male

White

6. COLOR OR RACE
7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 3, 1879

9. AGE (In years
last birthday)
yrs.

77

10. IF UNDER 1 YEAR
Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired Col.

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Army

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles H. Diller

14. MOTHER'S MAIDEN NAME

Anna Saylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

WWI

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Regina B. Diller

Address
2 West Second Street,
Frederick, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Cerebral Thrombosis, right middle cerebral artery

INTERVAL BETWEEN
ONSET AND DEATH

72 hours

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last. 222.1

(b)

DUE TO

Arteriosclerotic Cardiovascular Disease

10 yrs.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

1. Diabetes mellitus 2. Acromegaly

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. g. p. m. 1920d. INJURY OCCURRED
While at work Nat while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6/5/1950, to 9/16/1956, that I last saw the deceased alive on 9/15/1956, and that death occurred at 1:00A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Dr. Henry V. Chase

M.D. East Church St., Frederick, Md.

9/17/1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
Sept. 19, 195622c. NAME OF CEMETERY OR CREMATORIUM
Arlington National Cem.22d. LOCATION (City, town, or county)
(State)
Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

DATE 18 Sept 1956

24b. REGISTRAR'S SIGNATURE

Frank R. Smith, Jr.

3.V.8

go i



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09317

131

Reg. Dist. No.

9321

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>MARYLAND</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosedale</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i>		d. STREET ADDRESS <i>5606 Taylor Road</i>	
First <i>T</i> Middle <i>M</i> Last <i>Edwards</i>		4. DATE OF DEATH <i>September 5 1955</i>	
5. SEX <i>Male</i>		5. COLOR OR RACE <i>White</i>	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>July 24, 1920</i>		9. AGE (in years last birthday) <i>36</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Reed Research Inc.</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Marion Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Franca A Prober</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>064-09-9758</i>	
17. INFORMANT <i>Frances Edwards</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>X</i> DUE TO <i>Shock - Rupture of diaphragm</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b) Fracture (5) ribs on left side</i>			
DUE TO <i>Rupture of spleen</i>			
(c) <i>Fracture of left thigh at joint</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <i>NO</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Automobile accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>10:30 a.m. 9/6 1955</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) <i>Bergs Road Frederick Md</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED <i>Sept. 8, 1955</i>	
EXAMINER'S NAME (Type) <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/11/56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington 9, D.C.</i>		24a. REG'D BY REGISTRAR <i>SEP 11 1955</i>	
		24b. REGISTRAR'S SIGNATURE <i>Ely S. Hickey</i>	

REED V. S.

AP 13 1956

CEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69318

9340

CERTIFICATE OF DEATH

Reg. Dist. No.

147

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Frederick MARYLAND		MARYLAND Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Rural-Mt. Airy		Rural Mt. AIRY	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
Wife		RD 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	HARVEY	B.	HAINES
4. DATE OF DEATH	Month	Day	Year
	9-21-		1956
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White		6-27-1875
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired Carpenter		General	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Haines		Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT		Address	
LEONARD HAINES		Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		9-18	
30IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Cerebral Hemorrhage	
(b)		Arterio Sclerosis - age 81	
DUE TO			
(c)		Uremic Poisoning	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 6, 1956 to Sept 21, 1956 that I last saw the deceased alive on Sept 19, 1956, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE C.M. VAN POOLE M.D.		9-22-56	
PHYSICIAN'S NAME (Type) C.M. VAN POOLE			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		9-23-1956	
22c. NAME OF CEMETERY OR CRYMATORY		22d. LOCATION (City, town, or county)	
Prospect		Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
C.M. WALTZ		ADDRESS	
Winfield, Md		DATE 9-22-1956	
		24b. REGISTRAR'S SIGNATURE	
		HARRY P. KUNKEL	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

V5 A15 (4)
1SM 9/55

BUREAU V.

JULY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

19319

9341

CERTIFICATE OF DEATH

Reg. Dist. No.

131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Pleasant		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Pleasant		d. STREET ADDRESS Mt. Pleasant	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Costley Jackson
4. DATE OF DEATH	Month September	Year 1956	Day
S. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 4, 1879
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Grafton E. Costley		14. MOTHER'S MAIDEN NAME Arrie Anna Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Viola Boyd		Address Walkersville Rt. 1 Frederick Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Longestine myocardial failure DUE TO		2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior clavicular CVD DUE TO		10 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 April</u> , 1954 to <u>Sept 7</u> , 1956, that I last saw the deceased alive on <u>Sept 6</u> , 1956, and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>8 Sep 56</u>	
ACTUAL SIGNATURE <u>James S. Stoner</u>		M.D.	
PHYSICIAN'S NAME (Type) James Stoner		Walkersville <u>James S. Stoner</u> Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10-56	
22c. NAME OF CEMETERY OR CREMATORIUM Waymans Methodist Church		22d. LOCATION (City, town, or county) Mt. Pleasant Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR DATE 10 Sept 1956		24b. REGISTRAR'S SIGNATURE <u>Elinor S. Hack</u>	

1000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09320

9342

CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First Harry	Middle Last Kaetzel
4. DATE OF DEATH 9	Month 3	Day 3	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8-17-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.R.Co	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Christian T. Kaetzel		14. MOTHER'S MAIDEN NAME Mary Elizabeth Weddle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-4134	17. INFORMANT Laurence Kaetzel, Knoxville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)		DUE TO Prostate in prostat - CA?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-15-1956</u> to <u>9-3-1951</u> that I last saw the deceased alive on <u>9-3-1951</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) M.D. <u>B. Kaetzel</u>	
PHYSICIAN'S NAME (Type) Burke		DATE SIGNED <u>9-4-51</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-6-1956	22c. NAME OF CEMETERY OR CREMATORIUM Brethren	22d. LOCATION (City, town, or county) (State) Brownsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Lee Feltz</u>		ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE SEP 6 1956
		24b. REGISTRAR'S SIGNATURE <u>Eugenia Burke</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be starched for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

SEP 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9343

CERTIFICATE OF DEATH

19321

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Union Bridge</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>SAMUEL</i>	Middle <i>DESIGNER</i>	Last <i>KEENEY</i>
4. DATE OF DEATH <i>Sept. 11 1956</i>	Month <i>Sept.</i>	Day <i>11</i>	Year <i>1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14 1880</i>
9. AGE (In years last birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>	11. IF UNDER 24 HRS. Days <i>—</i>	12. IF UNDER 24 HRS. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Keeney</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Biddinger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-10-5805</i>	
17. INFORMANT <i>Mrs Samuel Keeney, Union Bridge, R.R. 2, Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bursal Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Sept 10 1956</i> to <i>Sept 11 1956</i> , that I last saw the deceased alive on <i>Sept 10 1956</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8 H. Missler M.D.</i>			
ACTUAL SIGNATURE <i>8 H. Missler M.D.</i>		DATE SIGNED <i>Sept 11 1956</i>	
PHYSICIAN'S NAME (Type) <i>8 H. Missler M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/14/56</i>	
22c. NAME OF CEMETERY Crematory <i>Rocky Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Mr. Woodsboro Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. L. Barton, Walkersville, Md.</i>		ADDRESS <i>—</i>	
24a. REC'D BY REGISTRAR <i>Eligible G. Heck</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>14 Sept 1956</i>			

SCHILLAU V. S

SEP 17 1956

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09322

9322

CERTIFICATE OF DEATH

Reg. Dist. No. 131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
<i>Frederick</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Frederick</i> 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. NEAR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick Memorial Hsp.</i> Thurmont	
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Catherine</i>		<i>S</i>	<i>Kelly</i>
4. DATE OF DEATH		Month	Day Year
		9	27 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	B. DATE OF BIRTH <i>6/8/76</i>
8. AGE (In years last birthday)		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days Hours Min.
80 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Housewife</i>		<i>Own Home</i>	<i>Maryland</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Nelson Barton</i>		<i>Clara Topper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
(If yes, give war or dates of service)		<i>None</i>	<i>Carmel Kelly</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>	
4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		<i>Acute Pulmonary Edema</i>	
(c) DUE TO		<i>Arteriosclerotic Heart Disease</i> 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Chronic Bronchitis</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/26</i> , 1956, to <i>9/27</i> , 1956, that I last saw the deceased alive on <i>9/27</i> , 1956, and that death occurred at <i>8:45 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Henry V Chase</i> M.D. <i>4 E. Church St</i> <i>Frederick Md</i>	
ACTUAL SIGNATURE <i>Henry V Chase</i>		DATE SIGNED <i>9/28/56</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>			
22a. BURIAL, CREMATION, REMOVAL <input type="checkbox"/> (y) Burial		22b. DATE THEREOF <i>10-1-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Carmel Cemetery</i>
22d. LOCATION (City, town, or county) <i>Thurmont</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Laymon K. Creager</i>		ADDRESS <i>Thurmont, md.</i>	24a. REC'D BY REGISTRAR DATE <i>Oct. 1-1956</i>
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth S. Hack</i>
VS A15 (4) 15M 9/55			

ELLEN V. S.

200 200

ELLEN V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69323

9323 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jefferson</i>		b. COUNTY <i>Frederick</i>	
c. LENGTH OF STAY IN TB <i>1 hour</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jefferson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Frederick Memorial Hospital</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Norma</i>	Middle <i>Jean</i>	Last <i>Kings</i>
4. DATE OF DEATH	Month <i>Sept.</i>	Day <i>19</i>	Year <i>1952</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 6, 1934</i>
9. AGE (in years last birthday) <i>18 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Roy Lee Kings</i>	14. MOTHER'S MAIDEN NAME <i>Marie S. Elliott</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Eleanor Morris Jefferson Ned</i>	Address <i>None</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Second degree burns</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Clothing caught afire</i> DUE TO (c) <i>2 hours</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Clothing caught afire</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Clothing caught afire</i>
20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 9/19 1952</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Jefferson Frederick Md.</i>		(County) <i>Frederick</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.C. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>		22d. LOCATION (City, town, or county) <i>Middletown, Md.</i> (State) <i>Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-22-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Reformed Cemetery</i>		22d. LOCATION (City, town, or county) <i>Middletown, Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladhill C. Middletown, Md.</i>		24a. REC'D BY REGISTRAR <i>Elizabeth D. Heiber</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

BUREAU Y.

SEP 25 1956

RECEIVED

1 **DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATIME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										19324 Reg. Dist. No. 131	
1. PLACE OF DEATH a. COUNTY Frederick					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 410 West Patrick Street			b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 West Patrick Street											
3. NAME OF DECEASED (Type or print) WILLIAM		First	Middle	Last	4. DATE OF DEATH September 16, 1956		Month	Day	Year		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 15, 1887	9. AGE (in years from birthday) 68 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Borderer		10b. KIND OF BUSINESS OR INDUSTRY Hosiery Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Henry King					14. MOTHER'S MAIDEN NAME Annie Castle						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. War I 214-10-2406		17. INFORMANT Mr. J. L. King - 410 W. Patrick St., Frederick,		Address Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4 days</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 8/11/56	
EXAMINER'S NAME (Type) Dr. E. O. Thomas											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/12/1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE C E Cline & Son - Frederick, Md.		ADDRESS		24a. REC'D BY REGISTRAR Elizabeth B. Herb		24b. REGISTRAR'S SIGNATURE					
				DATE 12 Sept 1956							

SEP 13 1956

THEATRE Y. B.

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9325 CERTIFICATE OF DEATH

09325
131

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial/transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 8 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 West Seventh Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FANNIE		First ESTELLE	Middle KOLB
4. DATE OF DEATH September 12, 1956		Month September	Day 12
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH December 6, 1877		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Gideon Remsberg		14. MOTHER'S MAIDEN NAME Alice Shellman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mr. John E. Kolb, Frederick, Maryland		Address 319 West Seventh Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hyperterension & Chronic Renal Insufficiency, Nephritis DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 12, 1956 , to Sept. 12, 1956 that I last saw the deceased alive on Sept. 12, 1956 , and that death occurred at 11:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas		ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 9/16/56	
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr.		Same as above	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Facility Frederick Memorial Park		22d. LOCATION (City, town, or county) Frederick, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison, & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 17 Sept. 1956	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hack	

REAU V. S.

DEP

REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119326

9335

CERTIFICATE OF DEATH

Reg. Dist. No.

141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Brunswick Street		d. STREET ADDRESS 403 Brunswick Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Llewellyn Last Lloyd		4. DATE OF DEATH 9 24 Month Day Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-1888				
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentist					
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Robert Lloyd		14. MOTHER'S MAIDEN NAME Elizabeth Ensor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) World War I		16. SOCIAL SECURITY NO. 212-38-8507					
17. INFORMANT <i>(If yes, give war or date of service)</i>		Address Mrs. Nellie Lloyd Brunswick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i>							
DUE TO <i>Neoplasm rt. lung (CA?)</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>							
Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause first. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Knoxville</i>	(County) (State) <i>Knoxville, Tennessee</i>
21. I certify that I attended the deceased from <i>8-1-1956</i> to <i>9-24-1956</i> , that I last saw the deceased alive on <i>9-24-1956</i> , and that death occurred at <i>7:30 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Knoxville, Tennessee</i> DATE SIGNED <i>Eugenia Burke</i>							
ACTUAL SIGNATURE <i>C.E. Pruitt</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>C.E. Pruitt</i>							
22a. BURIAL, CREMATION, Reform		22b. DATE THEREOF 9-26-1956		22c. NAME OF CEMETERY OR CREMATORIAL Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Fife</i>		ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE 8-28-1956		24b. REGISTRAR'S SIGNATURE <i>Eugenia Burke</i>	

BUKEAU Y. S.

SEP 29 1956

REC'D - V

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09327

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 25 East South Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First DANIEL	Middle THOMAS	Last LOWE
4. DATE OF DEATH	Month September	Day 9	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1884
9. AGE (In years to birthday) 72 yrs.	10. IF UNDER 14 YRS. Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Shovel Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lowe		14. MOTHER'S MAIDEN NAME Emma (Last Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7628	
17. INFORMANT Mrs. Katie Lowe, 25 East South Street, Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull		INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from truck & struck head on cement block	
20c. TIME OF INJURY Hour 10 a.m. 9/8 1956		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick
20f. (City or town) Frederick		(County) Maryland	
(State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 9/11/1956	
EXAMINER'S NAME (Type) Dr. B. O. Thomas Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS 19 Sept. 1956 Elizabeth Heck	
		24a. REC'D BY REGISTRAR Elizabeth Heck	
		24b. REGISTRAR'S SIGNATURE	

RECEIVED
SEP 13 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09328

9344

CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY	CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
RURAL - MT. AIRY		2 mo.		New Windsor						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Charles Edward Myers					9 - 16 - 1956					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male		White		5-9-1881	75 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
FARM WORKER		Farming		MARYLAND		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Lewis C. Myers		Julia E. Walker								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		None		Mrs. George Porter, Mt. Airy, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage (3rd stroke)				9/14				
381X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Arterio Sclerosis				days				
(c) Hypertension										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 9-14-1956 to 9-16-1956, that I last saw the deceased alive on 9-14-1956, and that death occurred at 5 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE		C. M. Van Poole, M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED				
PHYSICIAN'S NAME (Type)		C. M. Van Poole				9/17				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)				
BURIAL		9-18-1956		HOCUST & GROVE		Fred. C. Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
S. M. Waltz		Winfield, Md.		Date 4-17-56		Clarice A. Ruckles				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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RECEIVED

SEP 10 1968

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09329

9327

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 111 West Second Street								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First RICHARD	Middle FRANCIS	Last NALLIN	4. DATE OF DEATH	Month September	Day 7	Year 1956				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 26 Feb 1877	9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Professional Baseball Umpire				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Nallin				14. MOTHER'S MAIDEN NAME Bridget McHale								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Alice H. Nallin (Same as item #2)		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 m/s		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick		(County) Maryland	(State) MD				
21. I certify that I attended the deceased from Sept 6, 1956 , to Sept 7, 1956 , that I last saw the deceased alive on Sept 6, 1956 , and that death occurred at 5:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>E.P. Thomas</i>										ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md.	DATE SIGNED 9-7-56	
PHYSICIAN'S NAME (Type) E. P. Thomas, M. D.												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 Sept 1956	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland			(State) MD				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR Eligible L. Heeb	24b. REGISTRAR'S SIGNATURE					
						DATE 8 Sept 1956						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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2000



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9345 CERTIFICATE OF DEATH

19330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Myersville</i>		c. LENGTH OF STAY IN 1b <i>life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Myersville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Violet</i>	Middle <i>V.</i>	Last <i>Palmer</i>	4. DATE OF DEATH	Month <i>9</i>	Day <i>22</i>	Year <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>9-29-1898</i>	9. AGE (In years from last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 24 HRS. Days <i>7</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>J. Carlton Palmer</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Stettler</i>		Address <i>Hade Palmer, Myersville, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hade Palmer, Myersville, Md.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Suddenly</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Sept 23 1956</i> , to <i>Sept 22 1956</i> , that I last saw the deceased alive on <i>Sept 22 1956</i> , and that death occurred at <i>3 P. M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Middletown</i> DATE SIGNED <i>Elmer Harp</i> M.D. <i>Elmer Harp</i> M.D. <i>Middletown 9-23-56</i>							
ACTUAL SIGNATURE <i>J. Elmer Harp</i> M.D.		PHYSICIAN'S NAME (Type) <i>J. Elmer Harp</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-25-1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns Luth. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Rural Myersville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gladill C.</i>		ADDRESS <i>Middletown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>9-25-1956</i>		24b. REGISTRAR'S SIGNATURE <i>Doug M. Bittle</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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goat

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9328

CERTIFICATE OF DEATH

09331

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural		d. STREET ADDRESS Yellow Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle EDWARD	Last PLUMMER	4. DATE OF DEATH	Month September	Day 9,	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1873	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ticket Agent		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John D. Plummer		14. MOTHER'S MAIDEN NAME Margaret Kinna					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-5290		17. INFORMANT Mrs. Ida Plummer, Frederick R.F.D.#3, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis							
DUE TO X							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchial Asthma							
DUE TO (c) Sudden Cardiac Failure							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1946 , to Sept. 9, 1956 , that I last saw the deceased alive on Sept. 9, 1956 , and that death occurred at 11:15 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D. East Church Street, Frederick, Md. 9/11/1956							
DATE SIGNED							
ACTUAL SIGNATURE H. Steiner							
PHYSICIAN'S NAME (Type) Dr. H. J. Slusher		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 13 Sept 1956	
						24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

SEP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119332

9346

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LIBERTY TOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL		d. STREET ADDRESS 4302 N 4th ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAUDE ELIZABETH POFFENBARGER	First	Middle	Last	4. DATE OF DEATH SEPT 1 1956	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 10-1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JEREMIAH DUTROW		14. MOTHER'S MAIDEN NAME EMMA CRIST		Address MD RIDGELEY ALBAUGH LIBERTY TOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RIDGELEY ALBAUGH		INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon cancer Edema		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Carcinoma of breast & metastasis to Colon & liver		DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 1952 , to Sept. 1, 1952 , that I last saw the deceased alive on Aug. 31, 1952 , and that death occurred at 7A M , from the causes and on the date stated above. ACTUAL SIGNATURE B.O. Thomas M.D.		ADDRESS (Street, city or town, state) Frederick, Md					
PHYSICIAN'S NAME (Type) B.O. Thomas		DATE SIGNED 9/1/52					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/3/56		22c. NAME OF CEMETERY OR CREMATORIAL MT HOPE		22d. LOCATION (City, town, or county) WOODSBORO (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE D.Hartzer & Sons Union Bridge, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE 4 Sept 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heeb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

SEP 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9329 CERTIFICATE OF DEATH

(1933)
1933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b 10 min	b. COUNTY CARROLL	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL		d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First BABY BOY	Middle PRITTS	Last SEPTMBER 18 1956		
4. DATE OF DEATH	Month SEP	Day 18	Year 1956		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-56		
9. AGE (In years last birthday) — yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? ROBERT KYLE PRITTS		
13. FATHER'S NAME ROBERT KYLE PRITTS	14. MOTHER'S MAIDEN NAME ANNE LEE MORRIS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT FATHER	Address R.D. 2 SYKESVILLE MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURED - 20 WKS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 10 -		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> —	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 9-18, 1956 , to 9-18, 1956 , that I last saw the deceased alive on 9-18, 1956 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) HARRY W. GRAY, M.D. 35 E CHURCH ST. FREDERICK MD					
DATE SIGNED 8/18/56					
ACTUAL SIGNATURE HARRY W. GRAY	PHYSICIAN'S NAME (Type) HARRY W. GRAY				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-19-1956	22c. NAME OF CEMETERY OR CREMATORIAL EBENZER	22d. LOCATION (City, town, or county) CARROLL CO.	(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTERS, WINFIELD, MD.			24a. REC'D BY REGISTRAR DATE 20 Sept 1956	24b. REGISTRAR'S SIGNATURE Frank R. Smith, Jr.	

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SEP 21 1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9330

CERTIFICATE OF DEATH

Reg. Dist. No. 09334

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
Frederick				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frederick		6 hr. 30 ^{min}		Doubts	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frederick Memorial		Frederick Co.			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH
		Baby	Boy		9 - 8 - 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.
M		C		Sept. 8, 1956	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Frederick - Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Weedon		Betty Jane Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Charles Weedon Doubts	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Total Atelectasis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		Prematurity			
DUE TO (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 8, 1956, to Sept 8, 1956, that I last saw the deceased alive on Sept 8, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D. 220 N. WAKEFIELD ST			
PHYSICIAN'S NAME (Type)		FRED J. HEDRICK, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		9-11-56		Sunny-side	
22d. LOCATION (City, town, or county)		(State)			
Frederick Co. Md					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Charles E. Hicks IT Fred. Md.				DATE 13 Sept, 1956	
24b. REGISTRAR'S SIGNATURE		Elizabeth Heck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MRP 12 1966

DEPARTMENT OF
INTERNAL AFFAIRS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69335

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 724 days	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 724 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lester	First	Middle	Last Reese		
4. DATE OF DEATH September 23 1956	Month	Day	Year		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 23, 1893	9. AGE (in years last birthday) 58 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmund C. Reese		14. MOTHER'S MAIDEN NAME Bell Elsoared			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Deceased	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
4.1.1/ Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)					
DUE TO (b) DUE TO (c)					
Part II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (4 years)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 23, 1956, to September 23, 1956, that I last saw the deceased alive on September 23, 1956, and that death occurred at 5:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE I. B. Lyon	M.D. Cullen, Maryland		September 24, 1956		
PHYSICIAN'S NAME (Type) I. B. Lyon, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-26-56	22c. NAME OF CEMETERY OR CREMATORIUM Wesley	22d. LOCATION (City, town, or county) Carroll Co., Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edu. C. Tryton Harpstead Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 2/21/56	24b. REGISTRAR'S SIGNATURE I. B. Lyon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V.

SEP 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119336

9348

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feagaville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Feagaville		d. STREET ADDRESS Willis Derr Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willis Derr Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ASA	Middle EUGENE	Last RENN	4. DATE OF DEATH	Month September	Day 3	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1898	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 7	Hours 15	Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ USA			
13. FATHER'S NAME Asa B. Renn				14. MOTHER'S MAIDEN NAME Lottine Long					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-26-7737	17. INFORMANT Mrs. Ethel B. Renn, Feagaville, Maryland	Address Willis Derr Road, Feagaville, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis, recent</i> 15 min. <i>4:20.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <i>Arteriosclerotic Heart Disease</i> 6 yrs. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick	(County) Maryland	(State) Md.	
21. I certify that I attended the deceased from June 29, 1956 , to July 3, 1956 , that I last saw the deceased alive on 8/23/56 , and that death occurred at 8:20A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Henry V Chase</i>								ADDRESS (Street, city or town, state) East Church St., Frederick, Md.	DATE SIGNED 9/4/1956
PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 6, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery			22d. LOCATION (City, town, or county) Frederick, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR Elizabeth B. Heck	24b. REGISTRAR'S SIGNATURE		
						DATE 5 Sept 1956			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

SEP 7 1953

REGELVIE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

119337

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 4 Frederick		c. LENGTH OF STAY IN 1b 20 yrs		c. COUNTRY TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 4 Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle	Last RIDDLE	4. DATE OF DEATH Sept. 22 1956	Month Day Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1890 <i>workman's comp.</i>	9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Adam B. Riddle		14. MOTHER'S MAIDEN NAME Sarah Ray		Address RT 6 Mrs. Ethel Cole Riddle Frederick Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-5199		17. INFORMANT mrs. Ethel Cole Riddle	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Few minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		Arterio Sclerosis			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22 3 PM, 1956 , to Sept. 22 7 PM, 1956 , that I last saw the deceased alive on Sept. 22 3 PM, 1956 , and that death occurred at 7 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) New Market, Maryland	
ACTUAL SIGNATURE Ralph L. Michels		M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Ralph L. Michels					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Carmel Cemetery	
22d. LOCATION (City, town, or county) Frederick - Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son Frederick - Md.		W. ADDRESS		24a. REC'D BY REGISTRAR DATE 26 Sept 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth Y. Herb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be placed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

SEP 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keymar		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Augusta		Middle Clara	4. DATE OF DEATH Lost Smith
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6, 1865
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Zechariah Zeck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Curtis S. Smith
		Address Keymar R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis & Myocardial Degeneration		20 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1/2 X			
(b) Chronic Nephritis, Arteriosclerotic Kidney		20 years	
DUE TO (c) Generalized Arteriosclerosis		20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Fracture of Right Hip due to fall in home		5-9-56	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor in home	
20c. TIME OF INJURY Month, Day, Year Hour a. m. May 9 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
		(20f. (City or town) Keymar (County) Frederick (State) Md.)	
21. I certify that I attended the deceased from March 3, 1956 to September 16, 1956 , that I last saw the deceased alive on Sept. 14, 1956 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Taneytown Md.	
ACTUAL SIGNATURE R. S. McVaugh		DATE SIGNED 9/17/56	
PHYSICIAN'S NAME (Type) R. S. McVaugh			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Sept. 19, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Bever Dam Cemetery	22d. LOCATION (City, town, or county) Union Bridge-R.D. (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Tiss		ADDRESS Taneytown, Md.	24a. REC'D BY REGISTRAR DATE OCT 3 1956
		24b. REGISTRAR'S SIGNATURE A. H. Hendry	

OCT 3 1956

Sept. 14 26 26 26
Match 3, 66 September 16, 1956
Home Keweenaw Blagajefko, Mag.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9331

CERTIFICATE OF DEATH

Reg. Dist. No.

09339

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>3405 E White Ave</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Md. Oddfellows Home</i>				d. STREET ADDRESS <i>3405 E White Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Barbara</i>	Middle <i>Marie</i>	Last <i>Smith</i>	4. DATE OF DEATH <i>September 15 1956</i>	Month <i>September</i>	Day <i>15</i>	Year <i>1956</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 6 1881</i>	9. AGE (in years (at birthday) <i>75</i> yrs.)	IF UNDER 1 YEAR <i>75</i> Months	IF UNDER 24 HRS. <i>75</i> Days	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Henry J. Hebrank</i>				14. MOTHER'S MAIDEN NAME <i>Mary Thalheimer</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Nanay Mac Cubbin, 3405 White Ave.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>High blood pressure</i>						<i>13 days</i>			
DUE TO <i>Arterio sclerosis</i>									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3405 E White Ave</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Sept. 15, 1956</i> to <i>Sept. 15, 1956</i> that I last saw the deceased alive on <i>Sept. 14, 1956</i> and that death occurred at <i>3405 E White Ave</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>3405 E White Ave</i>		DATE SIGNED <i>Sept. 18, 1956</i>	
ACTUAL SIGNATURE <i>H. J. Hebrank</i>				M.D.					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/18/56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>		24a. READ BY REGISTRAR <i>Sept. 18, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Ely G. Hebrank</i>			

REGELVÆRELSE

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LJUNGBAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09340

CERTIFICATE OF DEATH

Reg. Dist. No.

9351

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Mt. Airy</i>	c. LENGTH OF STAY IN 1b <i>36 yrs</i>	b. COUNTY <i>Frederick</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Mount Airy -</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>	d. STREET ADDRESS <i>Route 2 - Buffalo Road</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Thomas Hillary Smith</i>	First	Middle	Last
4. DATE OF DEATH <i>September 30 1956</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 26, 1888</i>
9. AGE (In years (at birthday) <i>68</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>8</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Dennis Smith</i>	14. MOTHER'S MAIDEN NAME <i>Susan Catherine Long.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <i>219-36-0429</i>	17. INFORMANT <i>Mrs. Thomas H. Smith, Rt 2, Mt. Airy</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>7 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October 1, 1955</i> , to <i>September 30, 1956</i> , that I last saw the deceased alive on <i>Sept. 1, 1956</i> , and that death occurred at <i>5:10 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Mt. Airy, Md.</i> DATE SIGNED <i>9/30/56.</i>			
ACTUAL SIGNATURE <i>W.B. Culwell</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10-3-1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Sams Creek Brethren</i>
22d. LOCATION (City, town, or county) <i>CARROLL Co., Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. M. Waetz</i>		24a. ADDRESS <i>Winfield, Md.</i>	24b. REGISTRAR'S SIGNATURE <i>R. St. John</i>
VS A15 (4) 15M 9/55		DATE <i>T 2 1956</i>	

BRUNNEN

OCT 2 1960

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1934

9352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Elizabeth	Last Stitely	4. DATE OF DEATH	Month Sept.	Day 24,	Year 1956,
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Feb. 12. 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME David Martin		14. MOTHER'S MAIDEN NAME Elizabeth Holtz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. No		17. INFORMANT Wm. D. Stitely		Address Thurmont, MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 hour								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Cerebral hemorrhage 19 yrs ago 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from See , 1937 to Sept. 24 , 1956, that I last saw the deceased alive on Sept. 24 , 1956, and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, MD DATE SIGNED James K. Gray								
ACTUAL SIGNATURE James K. Gray		NAME (Type) James K. Gray						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 27. 1956		22c. NAME OF CEMETERY OR CREMATORIUM Blue Ridge Cem		22d. LOCATION (City, town, or county) (State) Thurmont Fredk Co. Md		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, MD		24a. REC'D BY REGISTRAR DATE Oct 1 1956		24b. REGISTRAR'S SIGNATURE L. H. Hendrichs		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
LIBRARY

OCT 1 1956

U.S. GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09342

Reg. Dist. No. 141

1. PLACE OF DEATH a. COUNTY		Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Knoxville		Life		c. STATE Maryland b. COUNTY Frederick					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Fred		M		Webber	9	II	19	56			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Male	White			10-30-1922	33 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Carman		B.&O.R.R.Co		Maryland		U.S.A.					
13. FATHER'S NAME		William R. Webber		14. MOTHER'S MAIDEN NAME		Anna Mary Nunburger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
World II		216-14-6428		Mrs. Evelyn Webber		Knoxville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed & dismembered body</u> DUE TO <u>Stamp by B.T.O.R.R. Train</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>B.T.O.R.R. Train</u> (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was on B.T.O.R.R. Train & was struck by</u>											
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
Hour 7:30 p.m. 9-11 1956		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Railroad track		Knoxville		Frederick			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>B.O. Thomas</u>		EXAMINER'S NAME (Type) B.O. Thomas Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Sept. 13-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-1956		22c. NAME OF CEMETERY OR CREMATORIAL Reformed		22d. LOCATION (City, town, or county) Knoxville (State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.O. Thomas</u>		ADDRESS Brunswick, Maryland		22e. REGISTRATION DATE SEP 14 1956		24b. REGISTRAR'S SIGNATURE <u>Eugene Burke</u>					

Volume V. 2

1940-1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9332 CERTIFICATE OF DEATH

119343

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN* (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rt. #3 - Nr. Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JOHN	Middle W. T.	Last WILES	4. DATE OF DEATH	Month September	Day 23	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 3, 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas McClary Wiles				14. MOTHER'S MAIDEN NAME Ella May Hilderbrand				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service] None		17. INFORMANT Mrs. John Wiles - Rt. 3 - Frederick, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) 420.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [If either, NOTIFY MEDICAL EXAMINER]		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middleton	(County) Middlesex	(State) Md.
21. I certify that I attended the deceased from Sept 22, 1956 , to Sept 23, 1956 , that I last saw the deceased alive on Sept 23, 1956 , and that death occurred at 6:00 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Richard O. Thomas, Jr.				ADDRESS (Street, city or town, state) Professional Building - Frederick, Md.		DATE SIGNED Sept 25, 1956		
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas, Jr.		Professional Building - Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 26, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middleton		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick - 2nd		24a. REC'D BY REGISTRAR DATE 26 Sept 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herk		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V.

SEP 27 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09344

9333

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick		Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		Maryland	
frederick		4 days		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		New Market	
		Green Valley Rd (Md 75)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Cassie				WILLIAMS	Month 9 Day 14 Year 1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years less birthday) 60 yrs.
F		N		Ken known	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife		—		Maryland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?			
CHARLES BOWIE		American (US)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		—		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
260X DUE TO Cerebral hemorrhage 1 day					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arterio sclerosis (long. heart failure) app. 10 yrs.					
DUE TO (c) Diabetes mellitus 5 years. long heart failure first					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
882 Comminuted fracture of left femur 19. WAS AUTOPSY PERFORMED? Car accident Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. Feb. 20 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
(County) Frederick		(State) Md		20f. (City or town) Frederick	
21. I certify that I attended the deceased from July 5, 1956, to Sept. 14, 1956, that I last saw the deceased alive on Sept. 14, 1956, and that death occurred at 545 P.M., from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) New Market, Md. DATE SIGNED					
ACTUAL SIGNATURE Ralph L. Michels					
PHYSICIAN'S NAME (Type) Ralph L. Michels					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT 17-56		22c. NAME OF CEMETERY OR CREMATOR Y SIMPSONS CHAPEL CEM 22d. LOCATION (City, town, or county) NEW MARKET MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Falconer		ADDRESS New Market, Md.		24a. REC'D BY REGISTRAR DATE Sept 17-56	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

STATE GOVERNMENT OF HAWAII - DIVISION OF
CERTIFICATE OF DEATH

BUREAU V. S.

SEP 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9334

CERTIFICATE OF DEATH

19345
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 33 East 4th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle ELLSWORTH	Last WISNER	4. DATE OF DEATH September 8, 1956	Month September	Day 8	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH February 9, 1882	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Brush Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ USA	
13. FATHER'S NAME John Wisner		14. MOTHER'S MAIDEN NAME Marzella Phebus					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2749		17. INFORMANT Mrs. Agnes F. Wisner		Address 33 East Fourth Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 33 IX					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 33 IX		DUE TO (b) Cerebral Hemorrhage 16 Hours					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 16, 1955 , to Sept. 8, 1956 , that I last saw the deceased alive on Sept. 8, 1956 , and that death occurred at 7:50P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church Street, Frederick, Md. DATE SIGNED 9/11/1956							
ACTUAL SIGNATURE H. J. Slusher		PHYSICIAN'S NAME (Type) Drs. H. J. Slusher Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR Elizabeth G. Heath		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heath	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNMENT RECORDS
CERTIFICATE OF DEATH

BUREAU V.

SEP 13 1956

RECEIVED